2.a. Outpatient Hospital Services (Continued)

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved **medically necessary** services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- Dialysis
- Radiation therapy
- Chemotherapy administration
- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Factor 8 injections
- Burn therapy

Treatment/therapy services are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

2.a. Outpatient Hospital Services (Continued)

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved **medically necessary** services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- Dialysis
- Radiation therapy
- Chemotherapy administration
- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Factor 8 injections
- Burn therapy

Treatment/therapy services are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

2.a. Outpatient Hospital Services (continued)

Outpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901 (7) (D) and (E) shall be eligible to receive outpatient hospital access payments. The outpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid outpatient hospital payments. The outpatient hospital access payments shall be determined on the basis of cost and calculated as follows:

1. **For each rate year the state shall identify, on the basis of paid claims adjudicated through the State's MMIS, reimbursement for outpatient hospital services that were delivered by the private hospitals eligible for this supplemental payment.**
2. **The state shall estimate the amount of cost for the same dates of service identified in step one using Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The State will utilize cost data in a manner approved by CMS.**
3. **The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of step one (Medicaid based payment) and results of step two (Medicaid outpatient hospital services cost).**
4. **The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals identified in step three shall be divided by the total Medicaid outpatient hospital services base payment for eligible hospitals identified in step one to arrive at an adjustment percentage. This percentage will be calculated annually.**
5. **Each eligible hospital's outpatient hospital access payment shall be determined by multiplying the Medicaid outpatient hospital services payment identified in step one by the adjustment factor determined in step four. The current year's adjustment will be based on cost data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.**

Outpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their outpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

(2) Pediatric Hospitals

Effective for claims with dates of service on or after April 1, 1992, outpatient hospital facility services provided at a pediatric hospital will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. **The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments.**

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost

settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect prior to the September 29, 1989, rule change.

2.a. Outpatient Hospital Services (continued)

(3) Arkansas State Operated Teaching Hospitals

Effective for cost reporting periods ending June 30, 2000 or after, outpatient hospital services provided at an Arkansas State Operated Teaching Hospital will be reimbursed based on reasonable costs with interim payments in accordance with 2.a.(1) and a year-end cost settlement.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed as described in Attachment 4.19-A, Page 8a for inpatient hospital services.

(4) Augmentative Communication Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for an Augmentative Communication Device Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech therapy is $25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is $18.22 per (15 mins.) unit x's 4 units per DOS equals a total of $148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of $297.92.

(5) Outpatient/Clinic-Indian Health Services

Effective for dates of service on or after November 1, 2002, covered outpatient/clinic services provided by Indian Health Services (IHS) and Tribal 638 Health Facilities will be reimbursed the IHS outpatient/clinic rate published by the Office of Management and Budget (OMB). Covered IHS outpatient/clinic services include only those services that are covered under other Arkansas Medicaid programs. This rate is an all-inclusive rate with no year-end cost settlement. The initial rate is the published IHS outpatient rate for calendar year 2002. The rate will be adjusted to the OMB published rate annually or for any other period identified by OMB.